DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q. PUBLIC	7/23/1935	987654321X

INSTRUCTIONS: This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.

EXAMPLE | A | B | C | | 1 | 2 | 3 | | |

SECTION A - INFORMATION ABOUT YOU

1) On 7/1/2000, will **YOU** be working? **YES** [X] **NO** [ ] (If **NO**, go to **SECTION B**)

2) How many employees, including yourself, work for your employer?

Don't know [ ] 20 or more [X] less than 20 [ ] (If less than 20, **STOP**, go to Section B)

3) Do you have any group health coverage through your current employment?

YES [X] **NO** [ ] (If NO, STOP, go to Section B)

Please print the name of your employer, and information about your group health plan in the spaces below:

EMPLOYER NAME
MEGACONGLOMERATE INC.

ADDRESS
123 MAIN STREET

CITY
ANYTOWN

STATE
NY

ZIP
00000

NAME OF GROUP HEALTH PLAN
ABC INSURANCE CO

ADDRESS
456 FIRST AVE

ADDRESS

CITY
GOTHAM CITY

STATE
NY

ZIP
99999

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

SECTION B - MORE INFORMATION ABOUT YOU

1) Are **YOU** getting Black Lung (Coal Miner's) Medical Benefits?

YES [ ] **NO** [X] If **YES,** Date Benefits Began: M M – D D – Y Y Y Y

2) Are **YOU** now getting any medical services related to an illness or injury which occurred on the job, for which **YOU** have or will file a workers' compensation claim?

YES [ ] **NO** [X] If **YES,** Date of Illness or Injury: M M – D D – Y Y Y Y

If **YES,** Insurer Name

ADDRESS

ADDRESS

CITY

STATE

ZIP

OMB NO. 0938-0214

SAMPLE

(TURN PAGE OVER)